

**Kentucky Public Pension Work Group  
Health Care**

**FINAL REPORT:  
10/30/08**

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**Subcommittee Staff**

**Alayne White and Greg Haskamp, Finance Administration Cabinet**

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Subcommittee on Healthcare  
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Mona Ball, KEA

Mary Ann Blankenship, KEA

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Shirley Clark, Kentucky Retired State  
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Edwin Davis, FOP

John L. Davis, Arison Insurance  
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Gary Harbin, KTRS

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Bob Schrage, NKADD; Municipal  
Government League of Northern KY

Richard Shultz, KRS

Gerald Stewart, Kentucky Firefighters  
Assn.

John Stovall, Teamsters

Judge Tommy Turner, Larue Co. Judge  
Executive; Former President of KACo &  
Ky. Co. Judges Assn.

Robert Wagoner, KRTA

John Wilkerson, KEA

Wayne Young, KASA

The Healthcare Subcommittee of the Public Pension Workgroup was chaired by Deputy Personnel Secretary Tim Longmeyer, and brought together a broad collection of legislators, stakeholder groups, plan administrators, and healthcare professionals. Several meetings were held during July, September, and October; covering topics from GASB liabilities, wellness, disease management, bulk prescription drug purchasing, Medicare Part D, and employer group waiver plans.

Members of the subcommittee, both House and Senate leadership offices, plan administrators, and the general public were encouraged to bring forth testimony and relevant topics. It should be noted that Chairman Harry Moberly showed a serious dedication to the business of the subcommittee, as well as our stakeholder groups who were active participants and constant reminders of the employees they represent. Also, the Department of Employee Insurance, the Kentucky Retirement Systems, and the Kentucky Teachers' Retirement Systems were particularly responsive throughout the entire process. The goal of the committee from the outset was to take a prospective look into the health problems the Commonwealth faces and to develop real strategies to meet them head-on.

The subcommittee was ultimately successful in identifying several key factors to maintaining healthcare costs:

- A large portion of the Commonwealth's healthcare costs for employees could be substantially reduced through effective disease management and wellness efforts.
- A number of states (e.g. Alabama), public pension plans, and other employers have utilized Medicare Advantage plans to substantially lower the plan costs they face, without lowering benefits to employees; and these programs are sustainable for the foreseeable future and assist in lowering GASB liabilities.
- Nine plans have implemented Employer Group Waiver Plans to lower costs. It should be noted that in testimony many of these plans were relatively small.
- Other states like West Virginia, have also sought innovative solutions to deal with skyrocketing healthcare costs through the creation of trusts for favorable GASB treatment of liabilities
- Finally a key strategy among states and large employers is to maximize economies of scale by utilizing group purchasing plans for pharmaceuticals

What follows in this report is a summary of meetings and suggested policy options that will help the Commonwealth to address the challenges of healthcare that lie ahead, as part of a multi-effort campaign to reign in runaway costs.

**Kentucky Public Pension Work Group**  
**Subcommittee on Healthcare**  
**Executive Summary**

Rising healthcare costs have emerged as a national problem that has yet to be adequately addressed. States across the country have generally done a poor job of planning and managing growing costs. As a result of skyrocketing costs, and in an effort to deal with chronic underfunding head on, the Governmental Accounting Standards Boards issued accounting changes through directives #43 and #45 that require an up front accounting of healthcare benefits owed to employees. In practice, the action led to a significant “overnight” leap in the size of the unfunded liabilities states must account for in their pension and healthcare benefits. In Kentucky healthcare is a major driver of the state’s unfunded liability, still according to a massive new study by PEW charitable trusts, Kentucky has \$929 million set aside or other post employment benefits like healthcare, and is one of only 13 states to have any money set aside.<sup>1</sup>

Despite the funds which have been saved for employees, the costs continue to rise; however, they are only a symptom of the real problem which is that Kentucky is a poor health state. Statewide costs are rising dramatically as the population suffers from a number of lifestyle and treatable chronic diseases including obesity, heart disease, complications due to smoking, and diabetes, among others. Members of the Kentucky employees’ health plans suffer from the same types of chronic diseases that affect much of the state.

Pursuant to a suggestion from Senate President David Williams, Governor Steve Beshear amended his initial Executive Order establishing the Public Pension Work Group to include a new subcommittee on Healthcare. The subcommittee on healthcare is one component of several efforts that have exclusively focused on the task of managing healthcare costs for employees of the Commonwealth.

- The General Assembly, in its 2004 Extraordinary Session, created and charged the Kentucky Health Group Insurance Board (KHGIB) with the responsibility of involving all relevant stakeholder groups—representing employers and employees—in the task of designing a fair, affordable, and sustainable health care system for state employees. Since the Governor’s administration began, the KHGIB was in the process of engaging in a thorough examination of the options available for the 2009 health care package.
- Additionally, a Best Practices Committee has been established to solicit the input of private sector health care experts—representing both major employers and labor unions in Kentucky—to review our options and to identify and recommend innovative ways to provide affordable health care to state employees.
- Also, Cabinets across state government have been engaged in an ongoing Wellness and disease management campaign, spearheaded by the Personnel Cabinet. The goal is to change attitudes and a culture among state employees that perpetuates treatable chronic disease.

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<sup>1</sup> PEW Charitable Trusts. “Promises With a Price, State Fact Sheet: Kentucky,”  
[http://www.pewtrusts.org/uploadedFiles/wwwpewtrustsorg/Fact\\_Sheets/State\\_policy/FINAL\\_Kentucky.pdf](http://www.pewtrusts.org/uploadedFiles/wwwpewtrustsorg/Fact_Sheets/State_policy/FINAL_Kentucky.pdf).

**Kentucky Public Pension Work Group  
Subcommittee on Healthcare  
Summary of Meeting 7/24/08**

**July 24, 2008**

On July 24, 2008, Secretary Tim Longmeyer, called the meeting of the Healthcare Subcommittee of the Public Pension Work Group to order. Following a welcome and introductions, Chairman Longmeyer outlined tasks and timeframes for the subcommittee's work.

The subcommittee will focus on wellness, disease management, and sustaining retiree health care plans with report due to the Governor by November 1, 2008. Chairman Longmeyer circulated a subcommittee sign-in sheet and told members and the audience that anyone who has an interest may sign-up to be a part of the subcommittee.

**Presentation: Alabama Medicare Advantage Program**

Chairman Longmeyer then introduced Kathy Stein, Don Weber and Laurie Niff from Price Waterhouse Coopers (PWC), to provide testimony regarding the Alabama Medicare Advantage Program. Ms. Stein joined the subcommittee from Chicago via videoconference and Mr. Weber and Ms. Niff joined from Atlanta via teleconference.

Mr. Weber and Ms. Niff who are the consultants working with Alabama proceeded to give an overview of their work with the state of Alabama specifically the Alabama State Insurance Board.

Alabama calculated its Government Accounting Standards Board (GASB) 45 liability and found it to be staggering. To address this issue Alabama considered a move to a Medicare Advantage Program. The role of PWC was to determine if this move would lower costs and provide better benefits.

Mr. Weber said that a committee was formed to develop specifications for any Medicare Advantage Plan. PWC assisted in looking at the vendors who may be able to do this and assessed whether it would be worthwhile. An RFP was developed and circulated. A quick analysis of the submitted proposals determined that this would be a very positive way to provide benefits and see dramatic savings.

Ms. Niff followed Mr. Weber and related background information on the 4 private sector plans offered under Medicare Part C as an alternative to parts A and B.

- 1) HMOs—these were the first – they have a gatekeeper—no out-of-network
- 2) PPOs—similar to HMOs, but some out-of-network allowed
- 3) Private Fee For Service
- 4) Medicare Special Needs Plan

## **Results from Alabama**

Reduced GASB by 14%--841 million  
\$14 million in cash savings  
Retirees lost no benefits, in fact gained

In addition, Alabama established a trust fund to pay for the go forward costs. With the trust fund, cash savings, and several actuarial changes, Alabama reduced its GASB by 40%.

A subcommittee member asked about an article in the Birmingham News stating that the fund was running out of money. Mr. Weber said that this was not true and that Alabama is moving forward with the 2<sup>nd</sup> phase of its program. Ms. Niff said she would look at article.

Another subcommittee member asked about benefits for the "under 65" folks. Mr. Weber stated that the pays 100%.

## **Presentation: Fred Nelson, Commissioner, of the Department of Employee Insurance**

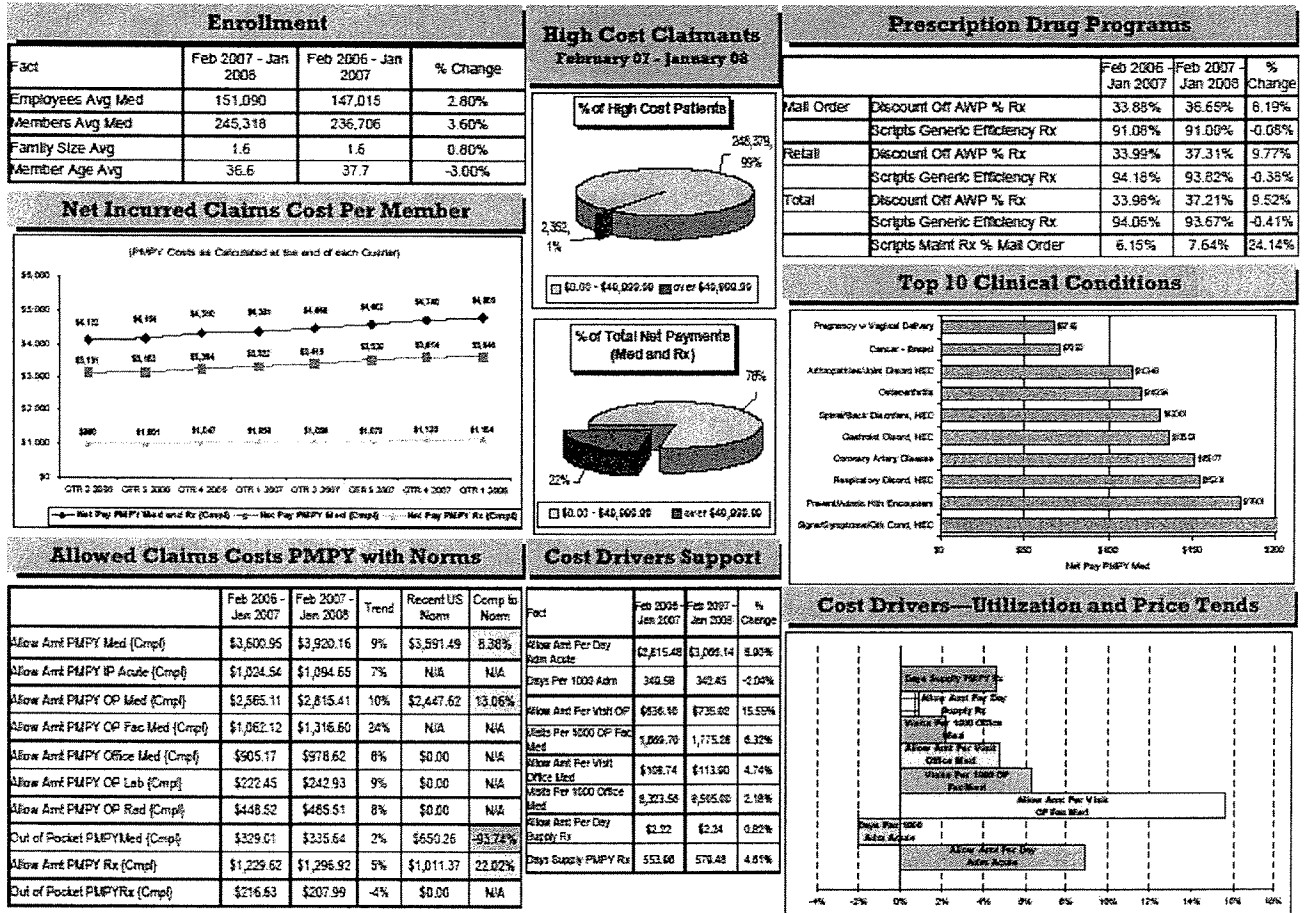
Fred Nelson, Commissioner, presented 3 key topics.

First, he clarified the roles of the Kentucky Employee Health Plan, (KEHP) the Kentucky Group Health Insurance Board (KGHIB), and the Advisory State health Insurance Subscribers.

Commissioner Nelson noted that a Comprehensive Monthly Report is provided to the KGHIB each month. At the beginning of each report is a "Dashboard" that gives a quick look at the reports' contents. The "Dashboard" discussed by Commissioner Nelson is below:

# DASHBOARD REPORT: BASED ON INCURRED CLAIMS

Includes Projections for Incurred, but Not yet Reported Claims (IBNR or CMPL)



Commissioner Nelson next addressed the Personnel Cabinet's pilot wellness program entitled "Journey to Wellness." This pilot, which only recently started, is quite exciting. **Wellness, preventative care, and disease management will be the cornerstone of future health care plans.** This shift in focus will be aggressively pursued as it may save 20-25% in plan cost.

A selection of the PowerPoint slides explaining the "Journey to Wellness" is below.

## Health Promotion at the Worksite

- The purpose of "Journey to Wellness" is to empower the employees to make healthier lifestyle choices and also, empower the managers and leaders to foster a healthier and more productive social atmosphere
- Worksites, managers and leadership support are crucial to improving the health of the employees. Most adults spend more of their waking hours at work than anywhere else, making it a prime venue for promoting healthful habits.
- The worksite organizational culture and environment are powerful influences on behavior and this needs to be put to use as a means of assisting employees to adopt a healthier lifestyle.

## The Need for Worksite Wellness

- Costs of Smoking
  - 28,000 employees shared that they smoke
  - Smoking-caused productivity losses in Kentucky \$2.13 billion
- Costs of Obesity,
  - 1 of 4 Kentucky adults are obese
  - #1 cause of chronic disease
- Cost of Diabetes
  - Commonwealth of KY's cost:
    - It is estimated that 29% of diabetes cases are undiagnosed, which means that an additional 127,200 Kentucky adults may have undiagnosed diabetes.
    - Based on these estimates, approximately 385,900 (about 12.5%, or 1 in 8) adult Kentuckians have diagnosed or undiagnosed diabetes.
- Cost of Heart Disease
  - KEHP cost:
    - Nearly 60 million American adults have high blood pressure (HBP)
    - One-third of them do not know they have the condition
      - 28% Kentucky adults have HBP
      - 38% have high cholesterol
      - 22% have never had their cholesterol checked



## Mission/Vision Statement

### Mission

- To promote and improve the health of Personnel Cabinet employees by empowering each employee to choose to lead a healthy lifestyle. Employees will be encouraged to participate in health screenings, worksite nutrition, physical activity and educational workshops in an effort to increase success on their Journey to Wellness.

### Vision

- Each Personnel Cabinet employee shall have an active lifestyle, a healthy weight, be a nonsmoker, and have normal cholesterol, blood pressure and blood sugar levels.

## What Will the Program Entail?

1st Phase:	2nd Phase:	3rd Phase:	4th Phase:
Know Your Numbers:	•Biggest Loser	•Physical Activity	•Prevention
Blood Pressure	–Health Coaching	–10,000Step	–Flu Shots
BMI	–Why Weight KY	–Get Walking	–Tobacco
Waist to Hip Ratio	–Weight Watchers	–Step	–Cessation
Total Cholesterol	–Diabetes Program	Pedometers	–Back Care
HDL	–DASH Diet	–Great American	–Health
Blood Sugar	–TLC Diet	Eat Right	Coaching
HHA Score	–Active For Life	Challenge	–AH Back Care
Heart Disease Risk	–Healthy Vending	–Community	–Mammograms
Cancer Risk Score	choices	Walk	–Pap smear
Diabetes Risk Score	–Nutrition Policy	–Health	–Annual
LUNCH N LEARN	–Healthy Meetings	Coaching	Physical
			–PSA
			screenings
			–Immunizations
			–Colorectomy
			screenings

In addition to the “Journey to Wellness” pilot program, Commissioner Nelson outlined the upcoming VirginHealth Miles Program. This program, currently under consideration, will be available to all employees and adult dependents statewide effective no later than 1/1/09 and will

be funded through current fee with Humana for wellness – no additional funding needed for 2009.

This is a computer-based program and it is platform based so that other behaviors can be incentivized, also.

### HealthMiles – Three Programs in One

- A physical activity & biometric monitoring program
- A universal incentives/rewards system
- A two-way communication/engagement platform

These programs act together to motivate members to take control of their health, make better choices and engage in the process of getting and staying healthier

## Three Key Platforms

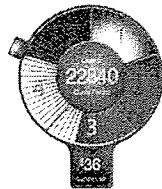
### Health & Fitness Tracking

- Physical activity tracking
- Biometric measurements



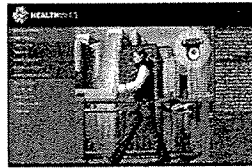
### Incentives/Rewards

- HealthCash
- Monthly Sweepstakes
- Rebate Center
- Quest Sweepstakes
- Personal Challenges



### Communications

- Activation Campaign
- Online user guide
- Monthly statements
- Periodic messaging
- Employer Reports (24/7)

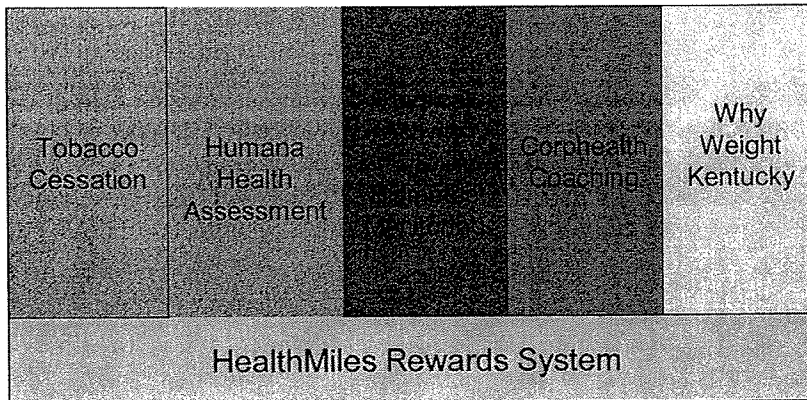


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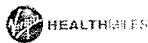


**HUMANA.**  
Centricity of where you need it most.

## Program Integration



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**HUMANA.**  
Centricity of where you need it most.

When Commissioner Nelson concluded his remarks, Kathy Stein reiterated the movement toward wellness and chronic disease management as the elements that will be at the forefront of

future health care benefits. Also, PWC has reviewed the VirginHealth Miles Program and deems it an excellent model for the benefit plan.

Chairman Longmeyer asked for questions and a suggestion was made to make better use of the local health departments. Commissioner Nelson noted that they are being used as an integral part of the Cabinet's efforts. Secretary Grayson's representative asked about the number of individuals who may cheat on the VirginHealth Miles Program. Commissioner Nelson did not know the answer to this question.

As the meeting closed, Chairman Longmeyer said that he looked forward to the future meetings of this subcommittee and that the subcommittee would focus on wellness, disease management, and sustaining retiree health care plans.

Chairman Longmeyer told subcommittee members that if they had questions before the next meeting that they could forward those to him.

With no further questions, the meeting was adjourned.

**Kentucky Public Pension Work Group  
Subcommittee on Healthcare  
Summary of Meeting 9/23/08**

**September 23, 2008**

On September 23, 2008, Subcommittee Chairman, Tim Longmeyer, called the meeting to order. Following a welcome and introductions, Chairman Longmeyer introduced the speakers. Jane Gilbert presented testimony on behalf of the Kentucky Teachers' Retirement System (KTRS). Mike Burnside, along with Rick Schultz, from Kentucky Employee Retirement Systems (KERS), also presented testimony to the subcommittee members.

**Presentation: Jane Gilbert for the Kentucky Teachers' Retirement System (KTRS)**

Ms. Gilbert's PowerPoint presentation and testimony covered the KTRS current health benefits, the history of plan design changes, the implementation of various cost savings measures, and future plans.

At this time, KTRS provides two health benefit plans for retirees:

Those under age 65 are covered by the Kentucky Employees Health Plan (KEHP).  
Those over age 65 are covered by the Medicare Eligible Health Plan (MEHP).

Currently, the KTRS MEHP provides benefits to 20,946 individuals including 17,347 retirees and 3, 599 spouses/adult handicapped children.

The average age of a KTRS retiree is 74. .... And 4,748 retirees are above 80 years of age.

In 2007, KTRS moved to a Medicare Advantage Private Fee for Service plan that mirrors the self-insured plan Medicare Complement plan in 2006. Humana administers the KTRS Medicare Advantage PFFS plan and the Medicare Eligible Health Plan. Medco administers the Medicare Eligible Prescription Drug Plan.

Significant changes to the KTRS health care plan include:

Increased prescription co-pays in 2000 and 2002  
Increased prescription deductibles in 2000 and 2003  
Increased medical deductibles and co-pays in 2003  
Increased Medical annual out-of-pocket maximum from \$1000 to \$1200 in 2003  
Member pays difference between generic and brand drugs initiated and enforce as of 2002  
Exclusion of life style drugs  
Exclusion of high priced GlucoWatch in 2003

In addition, KTRS utilizes two federal programs to contain health care costs. In 2006, with the Medicare prescription Part D program, KTRS realized an annual savings of over \$11 million. In

2007, the Medicare Advantage Private Fee for Service program brings an annual savings of over \$10 million.

Examples of other costs savings measures include ceasing spousal premiums and requiring a 15-year vesting period for teachers hired after July 1, 2008.

Regarding funding for KTRS, the medical insurance is on a pay-as-you-go basis (started in 1964). Medical costs have increased as well as the number of covered retirees. To cover these costs, almost one billion dollars has been redirected or borrowed from the KTRS Pension fund. There is a need for medical insurance funding to be in the General Fund budget rather than borrowing from the KTRS Pension fund.

Ms. Gilbert concluded her presentation by presenting the recommendation for future plans that the KTRS Board has approved:

- That the Board approve for KTRS staff to issue a Request for Qualifications (RFQ) for a broker/consultant for a Prescription Drug Plan, known as an Employer Group Waiver Plan under the Medicare Modernization Act, effective January 2010 to determine if an annual savings of \$5-\$15 million can be achieved with minimal benefit disruption to our membership. Should such a savings be recognized, there would be a significant reduction in the actuarial unfunded OPEB liability as projected by the KTRS actuaries and this would further stabilize member premium costs for the MEHP Plan.
- That the Board for KTRS staff issue a Request for Qualifications (RFQ) for an auditor to perform a 36-month prescription claims audit, a 36-month Medicare Part D subsidy audit, a dependent eligibility audit with amnesty period, plus any other health plan audits deemed necessary by KTRS staff. The dependent eligibility audit with amnesty period is to coincide with a permanent spousal election or waiver effective January 2010.
- That the Board approves KTRS staff to encourage the KEHP to explore joining the already established Ohio drug purchasing alliance, as long as the savings proves material and each agency may keep their autonomous plan design and separate pharmaceutical benefits manager contract. Any savings from this action would support funding the medical benefit for retirees.
- That the Board authorize a study be conducted and discussions with constituency groups take place to consider funding options for retiree health care that would ensure long-term funding of retiree health care and would have as a goal to end the practice of redirecting contributions from the retirement fund to fund retiree medical insurance. Such actions would consider equity for both retirees under age 65 and age 65 and older, active members and employers.

## **Presentation: Mike Burnside, and Rick Schultz, the Kentucky Retirement Systems (KRS)**

Following Ms Gilbert' presentation, Mike Burnside and Rick Schultz introduced a PowerPoint presentation and gave testimony regarding the history of the KRS health care benefits for the Medicare eligible retirees, the current plan status, and the future plans for improving the health plan benefit.

Mr. Shultz noted that prior to plan year 2006, KRS had historically been fully-insured. Given the numerous advantages to being self-insured, KRS released and RFP soliciting bids for:

- A single vendor to provide Third Party Administration (TPA) services on a national basis;
- A single vendor to provide Pharmacy Benefits Administration (PBA) services on a national basis;
- A national provider network was critical to a successful bid, to ensure adequate provider networks for out-of-state retirees.
- Benefits for 2006 would remain the same or close to those offered in 2005, with the same additional benefit plan options available:

Benefits of a self-insured system include:

- Lower Cost of Administration
- Carrier Profit Margin and Risk Charge Eliminated
- Claims/Administration
- Customer Service
- Cash Flow Benefit
- National Provider Network
- Control of Plan Design
- Mandatory Benefits are Optional
- Cost Reporting

Beginning in 2006 and continuing through 2008, KRS, under a 3-year contract has been implementing a self-insured, health care, benefit plan.

The self-insured plan covers 33, 413 participants -- 27,775 retirees and 5,638 spouses/adult handicapped children. By retirement system, KERS has 15,498 participants, CERS has 17, 498 participants, SPRS has 417 participants, and 12,000 individuals waive coverage.

In plan year 2006 there were several plan components that helped ease the transition to the self-insured model. The 2006 plan year benefit designs included the following:

- Premium Plan-Provides medical coverage supplemental to Parts A & B of Medicare.
  - Deductible: \$150/Maximum Out of pocket \$500
  - Drug coverage is unlimited
- Plus Plan- Provides medical coverage supplemental to Parts A & B of Medicare.
  - Deductible: \$250/Maximum Out of pocket \$1000
  - Drug coverage of \$3500

- Medical Only Plan—designed for retirees who wish to sign up for available Part D coverage outside of KRS
  - Deductible: Part B deductible level (\$135)
- Medical benefits apply to Medicare-covered services only and assume physician/provider accepts Medicare and Medicare Assignment.

The second year of the 3-year contract, plan year 2007, brought the following changes:

- The Anthem Medicare Advantage plans were not offered. There was limited utilization of the two plans and the Board decided to not renew the options for 2007.
- The drug cap for the Plus plan was increased to \$3500 in order to maintain creditable coverage as it related to the Medicare Modernization Act.
- Plan design changes were made to the pharmacy benefit that included increased pharmacy programs.

In the final year of the of the three year contract, plan year 2008, there was a required a minimal premium (\$1) increase for one of the 3 plan offerings. The other 2 plans premiums remained the same.

Noting that medical costs were down slightly from 2006 to 2007, but prescription drug costs continued to increase, four pharmacy management programs were added in 2008 --Compliance and Persistency, Appropriateness of Therapy, Inappropriateness of Therapy, and Specialty Pharmacy.

Mr. Shultz continued his testimony citing the numerous negative health problems plaguing Kentuckians—obesity, diabetes, cancer, and heart disease. To better address these serious health issues and produce better outcomes, Mr. Shultz stated that future plans will move toward an outcome focused strategy utilizing an aggressive case management programs.

Several of Mr. Shultz' PowerPoint slides illustrate the move toward this model of care:





## Transition Process

	Healthcare Today	Healthcare Tomorrow
Member Population Focus	Broad	The 10-20% identified health
Member Support	Limited to a few selected conditions	Case manager for those conditions
Provider Support	Limited to a few conditions	Case manager directed
Member Information	Fragmented	Centralized
Member Accountability	Entitled	Accountable
Cost-control Focus	Reduction of utilization/cost	Improvement of Outcomes
		Targeted Utilization Management
Outcomes Measurement	Limited	Clinical outcomes
		Standards of care
		Medical costs




## Case Management

- Facilitate patient centered coordination and management of care throughout the health care continuum.
- Focuses on coordinating services to promote quality, cost-effective care through benefit management, community resources.
- Foster Provider involvement in potentially catastrophic cases.
- **Empower** members by assisting them with the understanding of their disease or disability. It also allows the member a larger voice in the delivery of their care

As for the current KRS pharmacy benefit, Mr. Shultz noted that KRS has participated in the Retiree Drug Subsidy Program since 2006 and will continue to participate in 2009. The

reimbursement amount totals over \$35 million. These funds have been used for rate reductions but they cannot be used to reduce the OPEB liability.

KRS is currently looking at programs to reduce the OPEB liability including the Employer Group Waiver Plan (EGWP).



Financial Impact			
Annual net savings of 5-10% for self-insured program			
Savings for Rx are 20-25%			
Replaces current RDS program			
Reduction of OPEB liability and ARC of 15-20%, based on the June 30, 2007 valuation:			
	Current Valuation	EGWP Low Impact	EGWP High Impact
Unfunded Accrued Liability	\$8,658M	\$ 7,136M (\$1,522M reduction)	\$ 6,682M (\$1,976M reduction)
ARC	\$ 811M	\$ 699M (\$112M reduction)	\$ 651M (\$160M reduction)

Moving toward this plan, KRS let an RFP in June 2008 for a consultant to assist KRS with application to CMS. The RFP award was made in August 2008 and KRS plans submission in 2010.

There are numerous benefits to this move including a significant reduction in the OPEB liability.

At this point Mr. Shultz concluded his remarks.

Chairman Longmeyer asked for questions. There being none, the meeting was adjourned.

**Kentucky Public Pension Work Group**  
**Subcommittee on Healthcare**  
**Summary of Meeting 10/3/08**

October 3, 2008 Meeting

On October 3, 2008, Subcommittee Chairman, Tim Longmeyer, called the meeting to order. Following a welcome and introductions, Chairman Longmeyer introduced the speakers.

Don Maguire, Staff Vice President, WellPoint Inc., via teleconference, provided testimony regarding a national perspective for the OPEB liabilities. Following Mr. Maguire, Kathryn Friedman, Director of Plan Integrity, IPC, Inc. provided testimony, via teleconference, on Medicare Part D, discussing employer options and alternative strategies.

Mr. Maguire, referencing a handout titled "The Crisis in State and Local Government Retiree Health Benefit Plans: Myths and Realities," from July 2008, discussed OPEB from a national perspective and Medicaid Part D waiver plans.

Mr. Maquire began with a review of the Government Accounting Standards Board (GASB) Statement No. 43 and GASB 45. As state governments, counties, municipalities, schools, and other agencies come into compliance with GASB 45, they are discovering significant unfunded liabilities—nationwide 1.5 trillion dollars.

GASB is driving health care discussions as employers seek solutions for reducing their unfunded liabilities. One possibility is seeking a waiver from the federal government. This can be one of two ways—one as fully-insured such as with Anthem or a direct contract with CMS —both net out about the same. One is not necessarily better than another.

Mr. Maquire cited the presentation by Mr. Schultz at the September 23, 2008 meeting.

Mr. Maquire affirmed Mr. Schultz's explanation of the benefits of a waiver plan including:

- Significant reduction in OPEB liability
- Can be used to reduce retiree premium contributions or be earmarked as an OPEB Trust contribution
- Additional CMS payments for Low-Income Premium Subsidy and Catastrophic Reinsurance
- Flexibility to assume/assign administrative functions
- Complete flexibility (as long as meeting CMS minimums) in formulary selection, plan design, etc
- Can maintain current clinical and wellness programs
- No RDS application

At this point Mr. Maguire concluded his testimony.

Chairman Longmeyer then recognized the second speaker, Kathryn Friedman.

Ms. Friedman began her presentation by defining the current problem facing employers and framing the solution. Committee members have a handout of Ms Friedman's remarks and verbiage from that handout is often referenced below.

Per her handout, Ms. Friedman's states that CMS, seeking to prevent the further erosion in the availability and generosity of employment-based retiree coverage with the implementation of Medicare Part D, provided employers and unions with a set of highly flexible options designed to make it more affordable for them to continue providing high-quality prescription drug assistance to their Medicare-eligible retirees. The problem facing employers is which of these options to select to best meet their goals.

Ms. Friedman continues stating that public employee retirement system administrators are looking for options that will allow them to:

- Retain As Much Control as Possible of the Design of Their Retiree Drug Benefit
- Honor Collective Bargaining Agreements
- Retain Or Improve Retiree Drug Benefits
- Limit Rate of Cost Increases
- Minimize Projected Cost For Medicare Beneficiaries
- Post-65 Retirees
- Pre-65 Disabled
- Minimize GASB45 Reportable Liabilities
- Maximize Available Federal Subsidies

Ms. Friedman continues her presentation noting that four options are available to employers. Those options are 1) obtain the retiree drug subsidy; 2) contract with a prescription drug plan (800-series PDP) on a group basis; 3) offer a wraparound benefit to supplement the Medicare benefit; and, 4) become an employer group waiver plan (EGWP) direct contract prescription drug plan.

Ms. Friedman's presentation which can be found as attachment, thoroughly reviews the pros and cons for each of the four options. Given that KRS is looking at the EGWP, the pros and cons for that option per the handout are cited below:

#### Pros

- Sponsor has Maximum Control over Benefit Design And Processes

- Creditable Coverage Test for EGWP Simpler than for RDS
- If Benefit Is Creditable Coverage, Sponsor Can Match Existing
- Benefit And Meet Collective Bargaining Agreements
- Federal Subsidy as Upfront Monthly Premium Payments
- Federal Direct Subsidy Trending up through Time
- Subsidy Can Be Used to Reduce Member Premiums
- Subsidy Can Be Used to Offset Pharmacy OPEB Costs
- EGWPs Receive Part D Low Income Subsidy
- EGWPs Receive Part D Catastrophic Coverage
- Administratively Scalable to Size
- Can Group Enroll Beneficiaries in All Regions
- Can Limit Enrollment to Included Group Plan
- Flexibility To Enhance the Plan Design Options or Maintain
- Benefits that are at or Exceed Actuarial Equivalence

#### Cons

- Sponsor Continues To Assume Plan Cost Risk
- Higher (Some Say Onerous) Level of Operational And
- Compliance Oversight
- Substantial Reporting Requirements
- More Sensitive to CMS Rule/Regulation Changes

Ms. Friedman continues discussing additional benefits of the EGWP. These benefits per her handout include:

- Administratively Efficient
- National Enrollment, Limited to Participating Groups
- Includes Pre-65 Disabled and Post 65 Beneficiaries
- Flexibility To Directly Affect Plan Design Options
- Ability To Provide the Intended Retiree Benefit
- Option to Reduced Premiums through CMS Subsidy
- Allows For Lower GASB Reportable Liabilities (OPEB)
- Ability to Influence Member Satisfaction

·Maximized Financial Benefits from Negotiated Pharmacy  
Benefit Manager (PBM) Arrangement

Finally, Ms. Friedman gives two examples of entities that have moved to the EGWP from RDS—the Pennsylvania Public school Employees' Retirement System: 2007 and the Missouri Department of Transportation and the Missouri State Highway Patrol for 2007.

For PSERS that average number of employees is 37,279. Under the EGWP the Medicare Reimbursement amount is \$29,423,680. The RDS Medicare reimbursement amount is 17,972,045. The difference per beneficiary per month (PBPM) is \$25.70 with EGWP PBPM at \$65.77 and RDS PBPM at \$40.07.

For Missouri the average number of employees is 4,860. Under the EGWP the Medicare reimbursement amount was \$3,333,734 and under RDS the Medicare reimbursement amount was \$2,259,669. For the EGWP the PBPM was \$57.16 and for the RDS the PBPM was \$38.74.

For both examples, the operational costs of the EGWPs are higher, but the high reimbursement amounts make this an attractive option.

NOTE: Very few plans on a national basis have experience with EGWPs and of those many are relatively small in size.

At this point Ms Friedman concluded her remarks.

Chairman Longmeyer called for questions. There being none, the meeting was adjourned.

**Kentucky Public Pension Work Group**  
**Subcommittee on Healthcare**  
**Summary of Meeting 10/10/08**

October 10, 2008 Meeting

On October 10, 2008, Tim Longmeyer, Chairman of the Kentucky Public Pension Working Group Health Care Subcommittee called the meeting to order. Following a welcome and introductions, Chairman Longmeyer introduced Tim Snyder, Market Director, Humana Public Sector Business and Bob Walt, Humana National Business Executive for Retiree Medical Solutions to present "Public Sector Retiree Health Care Solutions." The presenters used a PowerPoint presentation as they provided testimony to the committee.

To begin, Mr. Snyder noted that Humana is "home grown," headquartered in Louisville, Kentucky and boasts 11.5 million total medical members. They have had some organic growth as well as recent acquisitions. Humana has been in the commercial space selling to private employers for a number of years and have been actively engaged in Medicare since 1985, with current Medicare membership at 4.5 million and growing.

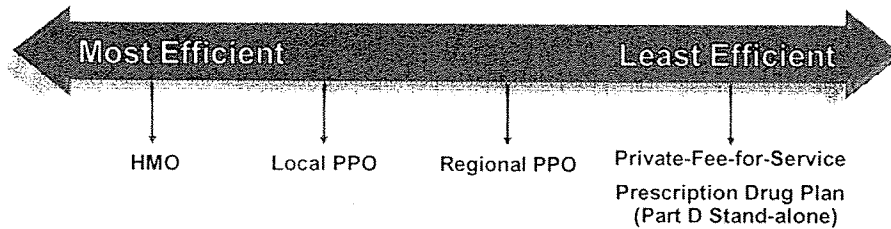
Mr. Snyder turned the microphone over to Mr. Walt to talk through their PowerPoint presentation.

Humana is working to build a platform that can be expanded to mid-sized–smaller cities that have the same type of problems as state retirement systems. Expanding the Medicare Advantage footprint is crucial as it fits well with retiree healthcare solutions.

Under Medicare Advantage – the options available now mirror what we've been doing for pre-65 and active employees for years, from private fee for service all the way to HMO options. Mr. Walt noted that clinical programs, including fitness and wellness are now built into Medicare Advantage. Mr. Walt commented that they are finding that seniors are not just taking care of medical issues, but they are finding the desire for fitness, wellness, and behavioral health solutions, too.

Mr. Walt referenced the following PowerPoint slides below that illustrate the range of services and the possible integration of services into one health care plan.

## Medicare Advantage: Spectrum of Solutions



- Benefits tailored to fit client circumstances
- May be "total replacement" or offered alongside Medicare secondary options, subject to underwriting guidelines
- Multiple product offerings can be combined to create greater choice of benefits under a migration strategy
- Medicare secondary and companion plans can also be offered in conjunction with Medicare Advantage plans

## Guidance: Health Resources



- Senior-focused care management to improve overall health status and promote efficient healthcare usage
- Rich offering of health and wellness programs to keep members healthier and engaged
- Focus on the integration of physical and mental health to manage total health and behavioral issues
- Designed to convert passive healthcare users into active health care consumers who work better with their doctor, make smarter choices, improve their health and save money



Mr. Walt continued saying that they are seeing a significantly lower usage of inpatient services and an increase in outpatient services. Readmission rates are also important to consider. With Medicare type programs that are built around the DRG reimbursement where once someone is admitted, the payment for Medicare is set. Health care plans need to be built avoiding hospitalization and a lower readmission rate.

Mr. Walt talks next of the significant under funding of retiree programs is for many states. Some, like Michigan, have implemented the program similar to the KTRS plan. The Medicare Advantage Program, for their population, is decreasing cost and liabilities and while increasing benefits.

Florida has a GASB workgroup that is working toward issuing an RFP to CMS. Part of the discussion in Florida is that the retirees are paying most of the premium but there is some GASB liability and the state is looking to reduce that liability.

Texas is coming to their next biennium and they have not implemented a plan yet.

When states are looking at their populations, they look at every age group – pre-65s all the way down to new hires. To address this, some retirement systems are starting to lay out a multi-year generational strategy, and sometimes that involves changing eligibility for future retirees, changing contributions for future or younger folks. The intent of retirement systems is to try to preserve the level of benefit (or enhance it) for current retirees or the soon-to-be retired.

Mr. Walt notes that the ratio of active employees to retirees is narrowing. In some states it's getting close to 1:1, which we've never had before. Typically the younger active employees have helped supported the cost of the retiree medical. That pressure is building in Kentucky.

At this point, Chairman Longmeyer asked Mr. Walt to talk in extensive detail about GASB and its implication on retiree health care benefits. Several of Mr. Walt's PowerPoint slides will be included below as he details GASB.

He begins by saying that GASB was an attempt by the accounting profession to make the measurement and recording of retiree health benefits transparent. For the most part they have been these costs have been reimbursed on a pay as you go basis, with no accounting for the liability.

The purpose of GASB is to make the accounting standards similar to a pension plan accounting where you have an annual required contribution to meet your cost and liability and if you're not funding that contribution you have an unfunded liability building. See below for GASB 43 and GASB 45 slides.

## New Financial Reporting Requirements under GASB

GASB Statement 43 establishes uniform standards of financial reporting for post-employment benefits other than pensions.

### Public Sector Includes:

- State and Local Government Employers
- Public Employee Retirement Systems (Staff)
- State Universities
- State Hospitals
- Utility Companies
- Public Authorities

### OPEB – Other Post Employment Benefits (other than pension) include:

- Dental
- Vision
- Prescription Drugs
- Medical Benefits
- Life Insurance
- Legal Services



## New Accounting Requirements under GASB

**GASB Statement 45** improves the relevance and usefulness of financial reporting by:

- **Accrual-based measurement and recognition** of OPEB costs over the employees' years of service, and
- **Present value accrued liabilities** of OPEB costs and to what extent progress is being made in funding the liabilities

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Importantly, GASB requires that the present value of any accrued liabilities is determined and reported. It is recommended that funding of the annual required contribution is preferable. However, if the annual required contribution is not funded, GASB requires any unfunded liability to be reflected on the balance sheet. GASB requires retirement systems to calculate the annual required contribution, plus any accrued future liability.

To the extent you have this annual required contribution for the whole retiree population, then pay benefits and pre-fund, that reduces the outstanding obligation that needs to go on the balance sheet. The obligation is the part of the annual required contribution that's not funded. This is accrual accounting, rather than pay-as-you-go.

This is a significant issue for retirement systems the annual retirement contribution and the ultimate accrued liability equals a significant increase in annual funding rates—much more than has been allocated on a pay-as-you-go basis of the past.

At this point Mr. Walt noted that Texas has determined that GASB does not apply to them. Mr. Walt then referenced a slide that identified 3 issues to consider if GASB funding is not provided.

### **What are the Implications of not Funding Part or All of the OPEB Obligation?**

There is no requirement that an employer must fund the total OPEB Obligation but...

- 1 The employer's bond rating, cost of debt financing, and the ability to borrow money may be adversely impacted
- 2 Rating agencies may include GASB 45 liabilities, pre-funding and risk mitigation strategy in financial analyses:
  - Standard & Poor's – December, 2004 & December, 2005
  - Fitch Ratings – December, 2004, June, 2005 & March, 2007
  - Moody's – April, 2005
- 3 Over time as those in the bond issuer's peer group begin to fund the OPEB Obligation, the "non funding" issuer may be behind the curve; it may become a credit issue

When we talk about putting a dent in the numbers, you don't have to pre-fund, but if you do pre-fund, GASB allows you to use a long-term discount rate when you're doing your evaluation, rather than a short-term rate. Each 1 percent increase in the discount rate can reduce the total GASB liability by 15-20 percent, so it is an advantage if you can use a higher discount rate.

Mr. Walt referenced other states like Alabama and South Carolina that are establishing irrevocable trust and a funding policy for the trust. They may not fund 100%, but by having the

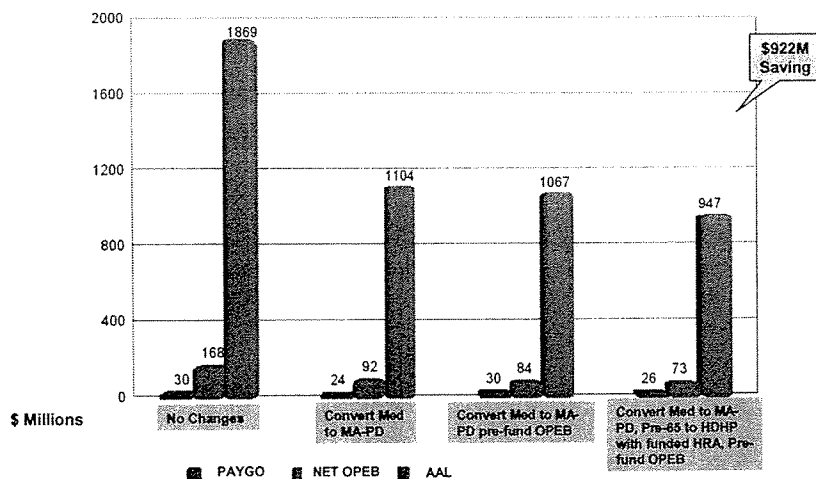
policy and establishing the trust, when their actuary does the evaluation, they can use a much higher discount rate. But it does have to be an irrevocable trust – money has to be used for the benefit of the retirees, and cannot be subject to creditors.

Mr. Walt next referenced his slides of several case studies. These studies are only meant to be directional.

#### Case Study #1

The first case study that Mr. Walt discusses describes a state in the southeast – about 38000 active employees and 9000 retirees. The state pays about half the cost incurring a significant liability. As well, the affordability is a big concern for retirees. They modeled changing the current program to a Medicare secondary plan (the plan pays after Medicare pays) – enhancing the benefits, adding new clinical programs – and took what the state retirement is going to save and using that to help pre-fund liability. They had a 6 million dollar savings. Their OPEB liability went from 186 million to 92 million. If they used their cash savings and put that in a trust to start pre-funding, they got to use a higher discount rate. This drives down the other two numbers. This takes down the ultimate unfunded accrued actuarial liability down around 800 million dollars (see slide below).

#### Impact on Pay-As-You-Go, Net OPEB Obligation and GASB 45 Unfunded Actuarial Accrued Liability for 2007



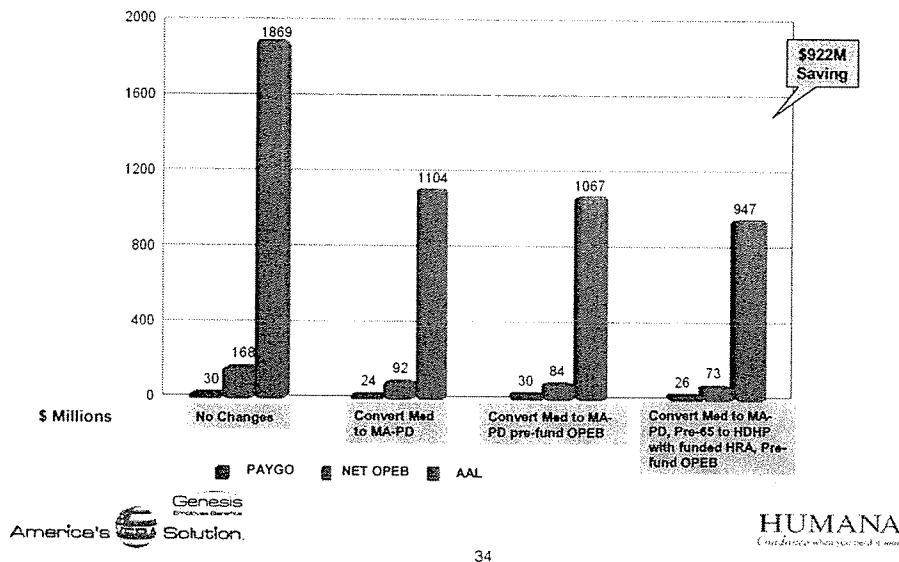
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Mr. Walt then described another case study of a state retirement system in the southeast. This state is contributing less than 20% toward the retirement medical, but many people t take advantage of it. The state is concerned with GASB liability and is modeling their demographics to determine possible savings. With possible savings the state looked at possibilities when they

take some of the savings and pre-fund. This creates additional savings. It takes their total ultimate liability from \$3.2 billion to \$361 million without increasing contributions or slashing benefits (see slide below).

### Impact on Pay-As-You-Go, Net OPEB Obligation and GASB 45 Unfunded Actuarial Accrued Liability for 2007



Mr. Walt notes that Humana works with a national actuarial consulting firm to develop these models. The models have certain assumptions built into it. The models are not 100% accurate, but give solid directional information for what can happen if these changes are implemented.

The remainder of Mr. Walt's presentation included a series of questions and answers. Those questions and answers are noted below.

Question: do the savings include the cost of implementing and operating the Medicare Advantage program?

Humana: It includes all the things that go into an insured rate. It does not include the administrative costs for the program you are running today vs. the costs of the new program. That would have to be determined if changing programs would increase or decrease costs. This includes all the communications, administrative costs, and claims paying. States like WV, PA, OH, MI, IL, LA, and WS can tell you how the administrative costs compare. It would be a small difference in administrative costs.

Question: you must factor in the difference of administrative costs.

Humana: Public school employees and civil service commission in Michigan offer a self-insured Medicare Advantage plan. We're not working with them, but we meet with them a lot. They're on the risk, but they are not dealing directly with CMS and taking on all that additional administrative, which is huge.

Question: was going to ask about where the savings come from, but I see there is another slide...

Humana: This information is all pulled from publicly-available information. This information is just meant to be directional. All sheets we give out say that you need to deal with your actuarial consultant.

For Kentucky, we did pull information from the GASB evaluation, which has your starting claims cost, your discount rates, obviously all your annual required contribution and projected liability. You would want to engage an actuarial consultant to run this same model. We are showing you the potential. This has to be part of a thoughtful strategic process. We think there is potential here, but you would definitely want to have an independent actuarial firm run this model (see slide below).

## Kentucky Retirement Systems

GASB Liability Expense Components	Current Medicare Secondary Plan	Implementing Medicare Advantage PFFS (total replacement) for all Post-65 Retirees	FY 2008 Savings	Using Medicare Advantage Annual Savings to Pre-fund GASB Liability	Added Savings	Total Savings
Annual Pay-As-You-Go Benefits Cost	\$92.9M	\$65.0M	\$27.9M	n/a	n/a	\$27.9M
GASB Annual Required Contribution	\$818.2M	\$605.5M	\$212.7M	\$335.5M	\$270.0M	\$482.7M
GASB Net OPEB Liability	\$398.6M	\$295.0M	\$103.6M	\$163.4M	\$131.6M	\$235.2M
GASB Unfunded Actuarial Accrued Liability	\$8.388B	\$6.207B	\$2.181B	\$3.439B	\$2.768B	\$4.949B

The first line is annual cash outlay, pay-as-you-go, second line is annual required contribution, and the bottom is the total projected actuarial liability.

The intent under the Employer Group Waiver Program that CMS has, which basically allows you offer a customized solution for an employer – is not to reduce any of the existing benefits whatsoever. So if you're not reducing benefits and not increasing cost-sharing, the question is, where do these kinds of numbers come from?

Alabama set up a qualified trust and are going to start pre-funding. I find that other states are very open to sharing their information.

Chairman Longmeyer noted that the subcommittee heard testimony last week that one of the PA retiree groups had done an EGWP and did not know if this was a result of that, or if this is a separate retiree group, or a state group, or if you knew that answer?

Humana: this would be a under an employer group waiver plan in that it was a customized plan for an employer. There is another PA group that's doing something different though. That group is the PEBTF. PA Employee Benefit Trust Fund – 52,000 Post-65 retirees – uses the program. PEBTF is fully-insured.

*NOTE: Humana made clear that administrative burdens increase as a result of EGWPs in the cases which they had observed.*

Another state retirement system you might want to touch base with is Michigan public school employees – they do private fee for service. They have about 116,000 post-65 retirees. Michigan civil service commission is closer to 30 or 40,000 post-65s. Ohio public school employees' and public employees' retirement system have offered private fee-for-service as their core plan, and they do offer other options. Most of their members are in the Medicare Advantage plan, but there are some on the other offerings. And other states – LA, KS, WS, ME – implement Medicare Advantage plans.

Question: Where do the savings come from?

Humana: When we look a retirement system, and then go through the model or price out a Medicare Advantage plan, we generally see a 20-40% reduction. What's driving that? There are a couple key components. When the Medicare Modernization Act was passed, there were incentives and subsidies built in for these types of plans to be expanded across the country to rural areas, smaller and mid-sized areas. When you get into some of those areas, typically a Medicare Advantage plan is paid by CMS plus incentives for expansion. Recently, a portion of that differential was cut back. In KY, as in a number of states, there is still a big differential. That is driven by where the retirees are located. Let's say you have an employer that is only in Jefferson Co., vs. state retirement system. Jefferson County works pretty well, but in a lot of rural areas, the incentives are higher. We certainly see that with the KTRS.

Question: have you ever had anyone talk about the impact of retirees' waiving coverage? In Kentucky, we have a substantial number of people who are eligible but waive – around 12,000. In this Medicare Advantage model, it seems to be foregone revenue. Is there a loss from that kind of selection?

Humana: Can't say we've studied that, and it's definitely something we should look at. Would be relatively easy to put a number on that.

One of the key things that's gone on here is why this works, why can the actuary assume a lower cost when doing projections – the fact that for this population, particularly a state retirement



system that has a significant number of people in rural areas – are these additional federal dollars that are coming in. It was all done by design. In the case of KTRS, we base our projections on where these retirees are located and take those subsidies into consideration. So, it's just bringing in additional federal dollars that aren't brought into a typical retiree program – that's one of the secrets. The other area is that the payments we get from CMS are risk-adjusted. So if a retiree covered by Medicare Advantage plan has three co-morbid conditions – severe diabetes, heart disease, and high blood pressure – our reimbursement from CMS is significantly higher for them than it is for someone who doesn't have those conditions. There is a base payment from CMS that includes these incentives, based on the county they live in, and adjusted for age and sex, but then it is also adjusted by the risk adjustment process. So it's really the first retiree medical program that has a very sophisticated risk adjustment process involved. So we actually get those payments. So when we determine how much premium we have to charge the retirement system and/or the retiree, we take that into consideration, and obviously that's going to lower the premium we need.

Question: are those risk adjustments given in the employee group waiver plans?

Humana: Yes. And they become real important for when we sit down with KTRS. It is all very transparent; all is presented to them.

We're all studying the impact of this. We now have a high-cost population that before was in Medicare and a supplement plan. Medicare was designed in the 60s. They've made some progress, but have fairly limited clinical programs. And then if you have a supplemental plan that maybe is paying 15 cents on the dollar, it doesn't make a whole lot of sense to invest a whole lot of money to develop elaborate clinical and case management. If you're doing that, you have to work something out to impact the total cost.

We see a significant difference when we move these populations into the clinical programs.

Question: what are some examples of clinical programs?

Humana: We are identifying people with serious conditions and getting them into complex case management programs. If need be, we're getting them into disease management programs – severe cancer, severe heart problems. You have someone on a one-on-one basis with them. Also, there is value to combining the behavioral health programs with the physical health programs. It's not unusual to have two chronic conditions, along with isolation or depression in seniors. A behavioral program example is treating depression. The member's case manager brings in a behavioral specialist. They are finding that the seniors love these voluntary programs. They welcome someone helping them coordinate their care.

Question: What percentage of your seniors takes advantage of these behavioral health programs?

Humana: There are different levels of care coordination – severe, not severe, etc. It's very important how you report those numbers. You can't count everyone who files a claim as part of a disease management program. We can share those numbers with you, but don't have it right now.

In certain programs like health risk assessment, the percentage of participation is 100%. When we reach out to people with claims, about 80 or 90% of those people join the programs. Regarding reimbursement from CMS, the monthly capitation payments we get (determined at the county level) are based upon the average cost and utilization under the traditional Medicare program. We're dealing with big numbers; it's an expensive population. What you look at is the actual experience for a particular group. What we're finding is that the claims experience is less than you would see under the traditional Medicare program. If your CMS reimbursement is \$100 more than the actual experience for that group that is \$100 that should be baked into the rating process and \$100 less that we would need from a given group. So you get significant additional federal dollars. When you put all that together, it's not unusual to see a system that has Medicare with a secondary program today, \$120-\$150 for the medical piece, another \$200 for the drugs, you start getting up to \$300-something. To see 30-40% off of that is pretty consistent, and that's taking into consideration recent adjustments.

For those systems that have a policy for pre-funding some of their future retiree medical liability, the discount rate drives the savings as well.

Question: the discount rate is an actuarial assumption, and does not affect what you're actually paying out.

Humana: Correct. But when you see that big number drop down (actuarial accrued liability), part of that drop is because of that assumption. But it does not, to your point, change the annual cash outlay.

Question: discount rates are developed after a study over time. Nobody's going to be raising their discount rate very soon.

Humana: Agree. We would raise a question about sustainability. We've done a pretty in depth study, and we're trying to make this a sustainable solution. When we look at a law like MIPPA, it's a relatively minor reduction that kicks in 2010. The reduction is capped, and phased in. Six-tenths of a percent is the cap for each year. Most all counties are impacted, because the IME cost is tracked to the member, back to the county they're in.

Private fee for service plans don't have a network like a PPO or HMO. You can go to any provider that accepts Medicare and the terms and conditions of the Medicare Advantage plan, but it's not really a contracted network. Beginning in 2011, private fee-for-service plans have to be network-based. What we did was study how much of the total IME payment was being reduced. *Explains slide of a map.* For a given county, you really need to look at the relationships of the Medicare Advantage capitation rate vs. traditional Medicare.

When we look at Kentucky, we have projected out to 2010 what we think the IME reduction rate is going to be. We're in pretty decent shape. *Shows slides to illustrate counties and their reductions.* After you take this cut into consideration, what types of products are needed to keep those savings sustainable? *Slide illustrates this.* All of the Medicare Advantage solutions should

continue to generate those savings. That being said, there will continue to be political and economic changes that will impact this.

We think we have a very manageable solution here with Medicare Advantage. The current arrangement is going to continue to generate significant savings. Doing some pretty in-depth actuarial analysis, we think KY is in pretty good shape.

Question: Can you explain plan design steerage?

Humana: That would be steerage to a network based solution, like a PPO. There's different ways you can do PPO. You can have a provider network. *Refers to slide.* In Cook County – Chicago, the relationship of the Medicare Advantage capitation to traditional Medicare is about a 1% difference. The reduction in IME costs is around 2%, so it would be a reduction in the overall payment there. Probably the solution that will work best there is more of a PPO or HMO with a provider. In a market like that, you would want to look at a strong PPO program on an optional basis.

Any kind of a program needs a 3-5 year game plan. Who knows what's going to happen with the global economy and state budgets?

Question: In your experience with states like Texas who chose to ignore the GASB funding issue, has anyone done a study that projects the point at which their funding becomes unsustainable?

Humana: The folks at the county level are very concerned about their GASB liabilities. The state of their economy will drive reasoned behavior inside TX. Their economy has been relatively good, and they haven't had the push they needed to take a look at it. Around other states, they are very concerned about the additional funding that is necessary on the pay-as-you-go basis.

Question: I was just in TX, and they got all the money they asked for in the budget for the current biennium. They're waiting to hear for the next biennium. There is concern this time around, unlike last time. You can't separate pension from healthcare. On the pension side, they've projected an 8% increase. Instead, they have a -4% change, so they have a 12% swing. Can we bring in federal dollars, keep benefits the same, take some of the pressure off, and help preserve the defined benefit pension plan? In TX now, there will be discussion about the 12% swing. The rules have changed in the last week or two.

Mr. Walt and Mr. Snyder concluded their presentation.

Chairman Longmeyer moved to the next Agenda item—Public Comment. There being no public comment, Chairman Longmeyer announced that the next meeting would be held on Friday, October 17, 2008 beginning at 10:00 a.m.

There being no further questions or comments the meeting was adjourned.

**Kentucky Public Pension Work Group**  
**Subcommittee on Healthcare**  
**Summary of Meeting 10/17/08**

October 17, 2008 Meeting

Chairman Longmeyer called the meeting to order with a welcome and introductions of subcommittee members. Next Chairman Longmeyer introduced the speakers who would provide testimony regarding the Ohio Drug Purchasing Alliance and the Transition to the Ohio Drug Collaborative.

Speakers included: Barry Rosenthal, Vice President, Express Scripts; Diane Brake, Executive Director, Express Scripts; Scott Streator, Ohio State University and the Ohio RX Collaborative; and Steve Farnen, KEHP, Express Scripts Manager.

Barry Rosenthal, in-person, opened and introduced his colleagues including Steve Farnen who was also in-person. Diane Brake and Scott Streator addressed the subcommittee via teleconference. Mr. Rosenthal then turned the program over to Mr. Streator.

Mr. Streator began with an introduction of the genesis of the ROC Program. There were three impetuses for the program – economic, political and clinical.

The Ohio retirement system, PERS, spent about \$1 billion on health care--the largest payer of health care outside of several government programs.

Mr. Streator noted that the smaller employers did not get the same discount as Ohio PERS or any of the retirement systems. At the same time, greater contributions were required. They started the initiative with PERS working with other large payers while still allowing autonomy in contracting – but how could they work together to achieve parity in pricing as well as a critical mass for strategy. They would benefit by adding more lives, and the smaller employers would benefit too. Mr. Streator said that they wanted to leverage the infrastructure in our state – clinical, academic, and business – to help Ohioans.

Mr. Streator continued saying the benefit for Ohio employers would be to improve access. They can save money through bulk purchasing while improving outcomes. They want to customize services through a national PBM. They really wanted to improve the physician-provider relationships. They needed a group of their peers to establish protocols.

Mr. Streator noted that there are 3 key strategies of the ROC. One is a loose collaboration of Ohio's public sector entities for pooled purchasing. This alone saved OSU \$9 million in the next 3 years of contract.

The second strategy is a population-based approach. Other states have formed various third party, clinical outcomes committees called Pharmacy and Therapeutic Committees. All practitioners would be able to buy into it once you reached critical mass. Physicians are

frustrated at the number of health plans out there. They would like to have just one, which would realize significant savings and improved outcomes. Another example would be looking for waste within therapeutic classes. The FDA does not do head-to-head comparisons, and they want the FDA to do that. It's difficult for the individual employer group to make recommendations of coverage, because they lack the expertise. Ohio PERS made the decision to start covering OTC drugs that had identical effectiveness to prescription drugs. Mr. Streater said that they saved \$15 million per year with this strategy. They could do this because of their size and that various advisory and clinical groups come together to do research and recommend best practices.

Mr. Streater continued saying that the third approach is all about personalizing medical and pharmaceutical care. They want to help patients by doing a comprehensive medication review. We're working on a joint venture with Express Scripts by identifying patients at risk and doing personalized medication review. Then they would talk to physicians and make recommendations, which could save money and improve outcomes.

Mr. Streater continued saying that they are leveraging the collective size, proximity, and talent of Ohio's clinical, academic, and business infrastructure. This seems to help when buying consumer items in bulk, like at Costco or Sam's Club. The pricing for employer groups goes down, dependent on volume.

Referencing the third strategy, Mr. Streater said that ROC involves a multi-disciplinary team that evaluates the medicines members are on to see if they are using the best, most cost-effective medicines for their condition. Savings can be realized through unbiased analysis of clinical value of medication. But overall we want to improve clinical outcomes.

Continuing he said that healthcare is local. Patients need to trust the practitioner. The program must be locally-driven and locally-supported for there to be a buy-in. .

Mr. Streater concluded his comments and asked for questions.

The questions and answers are as follows:

Question from Chairman Longmeyer: What are the limitations of the size or geographical diversity of a collaborative like ROC?

Answer from Mr. Streater: There is no limit to the number of lives we cover. We would be willing to work with Kentucky on sharing our learning experience.

Question from Chairman Longmeyer: Suppose this collaborative were to grow to multiple states. Is there a limitation on the cooperative effect – would you be limited by large increase in size or geographic area?

Answer from Mr. Streater: Of course we would like to partner with others. However, we have experienced so much growth lately. If you could give us some time, there might be a possibility

we could expand. I think, over time, once we get some of our programs up and running, I would be more than happy to consider how we could work together.

Question from Chairman Longmeyer: Mr. Farnen, what do you think the advantages and roadblocks to working with Kentucky?

Answer from Mr. Farnen: With the ROC, there is still some infrastructure that needs to be put in place, so nothing could happen immediately. We need to look at what the point of collaborative would be. If it's just for pricing, Kentucky is already in a great pricing situation. All the things you are doing today are a lot of the right things. What would be your intent in broadening into a collaborative? Would you want to broaden things to include other groups to help them? For your own group, you are in excellent shape, and I don't see the immediacy to joining a collaborative.

Answer from Mr. Rosenthal: Look back to what you can get out of the collaborative. In terms of price, you would want to do a detailed analysis to see if benefits can be realized beyond what you already get as a large purchaser. One of the other things you can achieve by concentrating efforts is that you achieve critical mass and you become the standard in a geographical area. You may take longer to make decisions when you have more stakeholders involved. The advantage of joining ROC is that it's already up and running. The disadvantage is that it may not be entirely consistent with what Kentucky wants to accomplish. There are a lot of things going for it; it's not right for everyone.

Comment from subcommittee member Mr. Burnside: I used to do purchasing for the state. In the past, we have done an agreement to be part of the MN purchasing group to get the benefit of the group cost. That was just for products, and this would add in services.

Question from subcommittee member: To be clear, what you are saying is that the discounts we are getting now are equal to or better than what Ohio's getting?

Answer from Mr. Farnen: That would require a detailed analysis. You're a large purchaser. *You may or may not be able to save something in administrative costs. The aggregated purchasing is only one value of ROC. You have to ask if it's worth it to you to have to run everything through the group, to try to match up philosophies.*

NOTE: Mr. Farnen was unclear as to the likelihood that such a collaborative would save the plans money. It is possible that they would not, due to the already aggressively low prices negotiated in the state's current contract with ESI.

Question from subcommittee member Mr. Young: I'd like to hear more about the personalized comprehensive medication review. What are the logistics? We have a lot of areas of our state that are underserved by physicians and pharmacies, as well as issues with pharmaceutical abuse.

Answer from Mr. Streator: This would require about an hour presentation to explain. The federal government is going in this direction. The Asheville project is using this model. The pharmacist would review the therapies they are using, and counsel the patient on their therapies.

Perhaps there would be an increase of the medications, or perhaps by interviewing the patient, they would find out about other medications they are taking that no one knew about, such as OTCs that don't show up in their records. They may cause interactions with prescriptions.

Question from subcommittee member Mr. Young: How do the physicians receive this information?

Answer from Mr. Streator: They are used to it, because this is the way they are trained now. If it improves the patient's outcome, they are happy to follow it.

Question from subcommittee member Mr. Young: How are you able to deliver that kind of intervention on such a large scale?

Answer from Mr. Streator: This phase is still in development. Our team is now looking at who really needs this. The first people to join this phase would be people who are on higher numbers of medications. Enforcing the prescription plan is the responsibility of the employer. Each local group has their own formulary, so to allow the local practitioners to trust it.

Answer from Mr. Farnen and Mr. Rosenthal: When Express Scripps started with Kentucky and combined Rx plans and implemented a number of new programs, there was a change for every member, it saved Kentucky \$43 million, and there is 97% satisfaction. One of the first steps was lowering generics to \$5. Educating and targeting members can work and still satisfy patients. ROC is beginning to implement academic detailing. Doctors don't have all the time to read all the literature, so they tend to prescribe the drug they have had experience with. They also don't always know what other drugs patients are on. Doctors tend to appreciate academic detailing. The goal is to raise the generic fill rate. Every percentage point that you increase the generic fill rate saves the plan one percent of the total cost.

Question from subcommittee member: Are you aware of any statutory or regulatory prohibition that may hinder collaboration?

Answer: The only legal hindrances I have heard of would be combining Medicaid with commercial and public employee and retiree plans. The laws regarding rebates would make that difficult. Other hindrances may be included in your state laws.

Question from subcommittee member: Are this approach and an employer group waiver program mutually exclusive?

Answer: Not that I'm aware of. The synergy you can get by combining lives is great with the clinical programs we're talking about.

Question from subcommittee member: Is this program running?

Answer from Mr. Streator: There are three phases. Phase 1, the purchasing, is up and running. We are forming the committees to work on the population-based strategies. We hope to have the personalized phase up and running in the first quarter of next year.

Chairman Longmeyer asked if there were further questions. Seeing none, chairman Longmeyer asked subcommittee members to submit recommendations for the final report. Anyone with recommendations is asked to submit them. For anyone wishing to report or give testimony, the next meeting is scheduled 10/24/08 at 2:00 p.m.

A draft report will be circulated following that meeting. The final report will be submitted on the 30<sup>th</sup>.

There being no further comment, the meeting was adjourned.



**Kentucky Public Pension Work Group  
Subcommittee on Healthcare  
Summary of Meeting 10/17/08**

October 24, 2008 Meeting

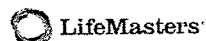
On October 24, 2008, Subcommittee Chairman, Tim Longmeyer, called the meeting to order with a welcome and introduction of subcommittee members. Chairman Longmeyer then introduced Charles A. Peck, MD FACP and Terese Odette, Director of Business Development from LifeMasters, who presented testimony on disease management.

Ms. Odette and Dr. Peck introduced themselves via teleconference. Ms. Odette began her testimony with an overview of the presentation. She said that she and Dr. Peck would discuss the LifeMasters program, their solutions for health improvement, and review their impressive outcomes. Ms. Odette notes that employers are looking for a disease management partner who:

**Other Similar Clients – Expressed Needs**

Looking for a partner who:

- Understands the difference between managing retirement systems and actively employed populations
- Understands YOUR fiduciary responsibility and the need to maintain fund solvency through control of overall healthcare spending, while at the same time improving health outcomes
- Delivers solid programs, cost savings and ROI by focusing on key chronic condition cost drivers
- Is experienced and has a successful track record with both an active and a high risk, aged population
- Can implement quickly, effectively and seamlessly to engage members and deliver results, both short-term and long-term
- Maintains continued focus on quality improvement and innovation
- Provides timely, effective reports that meet the needs of the organization and provides transparency
- Sees the relationship as a collaborative partnership, with a common culture and goals for success
- Believes in a genuine mission to improve health



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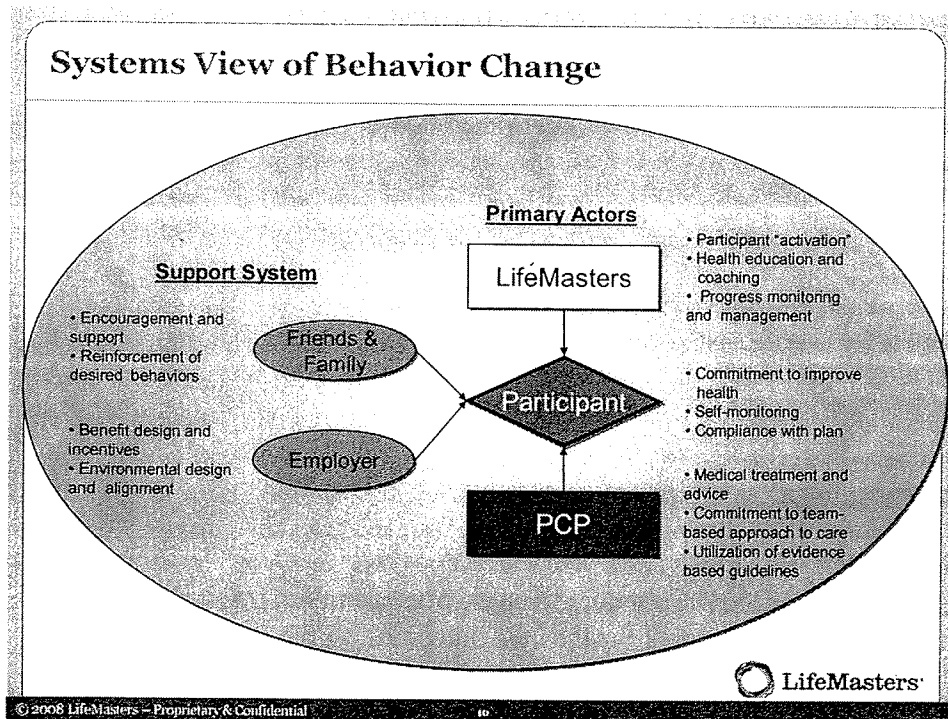
Ms. Odette said that LifeMasters is different from other disease management programs because LifeMasters focuses on three areas: 1) they work for the best outcomes on the conditions that are the biggest cost drivers; 2) they use scientifically-based and validated interventions with better processes; and, through a consultative, solutions-oriented approach, they provide better client service.

Ms. Odette noted also that LifeMasters has an award winning 14 year history, serves more than 450,000 participants, and has over 1,000 employees operating in 9 locations. LifeMasters offers clinical depth grounded in analytical rigor.

Ms. Odette recognizes Dr. Peck and he continues with their presentation.

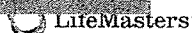
Dr. Peck begins by defining disease management and noting the numerous companies using their services. LifeMasters provides a disease management program that focuses only on certain conditions—the ones that are the most costly and difficult to manage. Those include asthma, COPD, CHF, CAD, diabetes, and hypertension. LifeMasters provides programming that is focused on behavior change. Dr. Peck also notes that LifeMasters has invested in a scientific approach to enrollment and engagement, better understanding participants' motivations and barriers. LifeMasters specializes in behavior change, working with the retiree, employer, family, friends and doctor, thereby increasing the odds of a good and less expensive outcome. The company addresses systems issues as well as utilizing evidence based motivational interviewing techniques. Success is due also in part to the primary nurse model—coaching model utilized by LifeMasters. Each participant has only one nurse who stays with them throughout the need. In addition, Dr. Peck notes the company's capabilities in working with complex cases and their specialty work in Advanced Care Planning.

Slide 10, below, visually denotes their systems view of behavior change. Slide 12, below, gives an overview of the products provided by LifeMasters. Slide 18 addresses Advanced Care Planning.



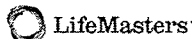
## Product Portfolio

	Current	New Capabilities / In Development
Healthy	<ul style="list-style-type: none"> <li>• Health &amp; Wellness</li> <li>• Healthy Eating</li> <li>• Inactivity</li> <li>• 24/7 Nurse Line</li> </ul>	<ul style="list-style-type: none"> <li>• Surveillance</li> </ul>
At Risk	<ul style="list-style-type: none"> <li>• Inactivity</li> <li>• Metabolic Syndrome</li> <li>• Obesity Management</li> <li>• Smoking Cessation</li> <li>• Stress Management</li> </ul>	<ul style="list-style-type: none"> <li>• Cardiac Risk Reduction</li> <li>• Disability</li> </ul>
Chronic	<ul style="list-style-type: none"> <li>• Core Diseases</li> <li>• Asthma, COPD, CHF, CAD, Diabetes, Hypertension</li> <li>• Cancer</li> <li>• Chronic Migraine, Headaches</li> <li>• Musculoskeletal/LBP</li> <li>• Stand-Alone Depression</li> </ul>	<ul style="list-style-type: none"> <li>• Co-morbid Depression</li> <li>• Arthritis</li> </ul>
Complex	<ul style="list-style-type: none"> <li>• Advance Care Planning</li> <li>• Case Management</li> <li>• High-Risk Maternity</li> <li>• Utilization Management</li> </ul>	



## Advance Care Planning

- ACP – A focus on end of life planning
  - Cancer Support Program
  - Geriatrics Program
- ACP is “normalized” as part of care support
- LifeMasters ACP Training
  - Nurse/Case Manager capability
  - Internal and external training of employees
- Program Goals:
  - Discuss and document individual patient values and wishes
  - Improve support for pain management
  - Improve understanding of hospice benefit
  - Identify and implement specific process for Advance Directive completion
  - Improve executed and distributed Advance Directive rates



Next, Dr. Peck discusses LifeMasters’ work with Medicare. He states that as of January 2008, LifeMasters is the only disease management company still working with Medicare. Work with Medicare has been continued because of the success LifeMasters has had with the patients. The

patient data was analyzed by Medicare and Medicare chose to continue working with LifeMasters due to its success. In Florida, the Medicare analysis of patient data indicated a 34% improvement in patients' health. Savings exceeded fees 3 months ahead of schedule.

Dr. Peck addresses success from a retirement system in Ohio. LifeMasters exceeded the guaranteed return ROI of 2:1, resulting in a net savings of almost \$5.9 million, a 3.11:1 ROI. In addition, 10 of 12 Clinical Guarantees were met and the patient satisfaction rate of 98.6% exceeded the 90% requirement.

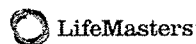
Dr. Peck returns the presentation to Ms. Odette. Ms. Odette addressed LifeMasters' extensive reporting capabilities—monthly, quarterly, annually, -- especially the reporting to the physicians.

Ms. Odette concludes the formal presentation with what LifeMasters calls the Critical Success Factors—the big 7.

### Critical Success Factors – The Big 7

Key learnings from 14+ years of implementing health improvement programs:

1. *Risking and Stratification of Members* – identification of members by disease severity and prognosis
2. *Quality, Timeliness and Accuracy of Data* – membership demographics, claims data (medical, pharmacy, lab etc...)
3. *Continuity of Membership Enrollment / Engagement* – capability to engage participant uninterruptedly for a one year minimum
4. *Member Communication and Incentives* – client sponsored communications endorsing program, adoption of best practices outreach materials (e.g. MVT factors), patient incentives, clinical campaign development/implementation
5. *Ongoing Service Model* – regularly scheduled meetings to review/modify mutually agreed upon account operations and strategies
6. *Organizational Sponsorship of Health Improvement Program & Value* – sales/account management, case manager and customer service education
7. *Provider Engagement* – development of cooperative care management model with network physicians; clinical campaign development/implementation



Question from Ms. White: What were the 2 clinical guarantees that were not met and why were they not met?

Answer from Dr. Peck: One measure was with flu shots. This indicator was set very high. However, if a patient gets a flu shot at Walgreens, rather than through the physician, and forgets to report it, then there can be significant under reporting. So that measure was low. The second measure was the percentage of patients with diabetes who had cholesterol checks. We missed

this indicator by one point. But a miss is a miss and Life Masters repaid the retirement system for the two missed indicators.

Question from Mr. Davis: Your services, while quite impressive, how do your services differ from what is provided by Medicaid Advantage? What is the percentage of population you focus on? Also how do you define engagement?

Answer from Dr. Peck: We focus on the 20% of issues/retirees that drive 80% of the costs. They engage 30-40% of this population and they triage their issues. LifeMasters is clinically deep and they laser in on the sickest of the population. With sophisticated predictive modeling analyses, we utilize all claim data to find their patients. LifeMasters really focus solely on disease management. LifeMasters is different because the patient drives the individualized program design. Medicare Advantage is focused more on claims and data rather than intensively/aggressively on disease management.

Dr. Peck defines engagement as actually talking with someone in the high or moderate risk group sometimes weekly and at a minimum of every six weeks. For lower risk folks a phone call at least quarterly and educational material is provided as well.

Question from Chairman Longmeyer: How many patients actively engage in the various levels of engagement?

Answer from Dr. Peck: The 450,000 are the ones who are actively engaged.

Question from Chairman Longmeyer: Overall what are your top 5 focuses be for the high to moderate risk populations?

Answer from Dr. Peck: First those who are in the hospital—aggressively try to keep them out of hospital. Second, getting patients actively engaged with their physicians so they do not rely on emergency room services. Third, compliant with medications, using most cost effective meds, and insuring they are not taking meds that negatively interact with one another. Fourth, there is a significant percentage of this population that has depression. Depression exaggerates their physical conditions and these must be addressed concurrently. We focus on depression in a stand alone program and we have a co morbid program.

Question from Chairman Longmeyer: What is your experience with smokers, those who are heavier than average and baseline indicators that are not good?

Answer from Dr. Peck: Florida and New Mexico are two states that have these negative indicators. They are working successfully with these states and especially with the weight and diabetes issues.

Question from Mr. Young: Can you discuss how you identify patients per slides 10 & 11? I guess I would like more information regarding participant activation and finding the right people with whom to intervene.

Answer from Dr. Peck: Activation is an issue that they have been working with the University of Oregon to create an effective activation model. Key to this model is listening to motivators as described by the patient. They look for what motivates individuals on the very first call.

Question from Mr. Burnside: How are pharmacists involved with drug interventions with your programming?

Answer from Dr. Peck: We do not have fulltime pharmacists. We do have pharmacists who consultant with us and we have a medical director who interacts with our nurses on medication and medication management.

Question from Ms. White: What training do you provided for your professionals nurses in the motivational interviewing techniques?

Answer from Dr. Peck: Four individuals are certified in motivational interviewing. These four are responsible for training all other nurses. We believe that it takes about ten months for someone to be adequately training in these methods.

Question from Chairman Longmeyer: Can you describe in more detail your surveillance activities per slide #12?

Answer from Dr. Peck: Regarding health and wellness, we have a partnership with StayWell. StayWell works with wellness and LifeMasters works with those at risk especially pertaining to smoking, weight, etc. Beginning January 1, 2009, StayWell will be a fully integrated partner.

Question from Chairman Longmeyer: What's involved in your surveillance capabilities? What are you putting into place?

Answer from Dr. Peck: As I said before, we use predictive modeling. We ask for all claim information and determine who is at low, moderate, or high risk. That is automatically run through our system. The surveillance piece can then help determine what services an employer want to contract for—low, moderate, high, or all of these. Again, our predictive modeling is very sophisticated.

Question from Chairman Longmeyer: Are you using surveillance for your term of identification? What do you after you id these individuals? How do you stay with them?

Answer from Dr. Peck: For low risks they stay in touch at least 4 times per year to see how they are doing. This contact also lowers costs.

Question from Chairman Longmeyer: Once they have engaged, what are you tracking methods?

Answer from Dr. Peck: Again, once they are a participant, eve if they are low risks, at very least 4 calls and various pieces of educational information. Nurses regularly make outbound calls and

patients can call inbound anytime. Beginning January 1, 2009 patients can reach nurses by email. They can now reach through internet.

Question from Mr. Davis: Have you conducted your program with any groups that provide financial incentives or any penalties? Incentives are popular now, what is your experience with this tactic?

Answer from Dr. Peck: There is much more of this in the wellness arena, but not in disease management. But right now, the incentive programs for disease management are minimal. But his experience is that the incentives do work with certain populations.

Chairman Longmeyer asked for further questions. There being none, Dr. Peck and Ms. Odette thanked Chairman Longmeyer and the subcommittee members.

Chairman Longmeyer moved to the next agenda item – a discussion of final report. It was stated that Greg Haskamp is still taking recommendations for the report and that a draft report will be circulated Monday morning, October 27, 2008.

If another meeting is needed it will be held October 29, 2008.

The final meeting to present the report is scheduled for October 30, 2008, in Room 327 of the Capitol.

There being no further business, the meeting was adjourned.

**Kentucky Public Pension Work Group**  
**Subcommittee on Healthcare**  
**Summary of Key Findings**

- Kentucky's healthcare costs for employees and retirees are driven by lifestyle and chronic diseases that can be treated and better managed if career employees are willing to participate in wellness and disease management programs.
  - The majority of Kentucky's plan participants are career employees; the time to encourage better health is during an employee's working years, which ultimately lowers the need for care and reduces costs in retirement.
- A number of states, public pension plans, and other employers have utilized Medicare Advantage plans to substantially lower the plan costs they face, without lowering benefits to employees
  - KTRS utilizes two federal programs within Medicare to contain retirement and health care costs. In 2006, with the Medicare prescription Part D program KTRS realized an annual savings of over \$11 million. In 2007, the Medicare Advantage Private Fee for Service program brings an annual savings of over \$10 million.
  - *Recent Federal Legislation has called into question the viability of these programs nationwide. Testimony was taken from Humana that despite federal changes the program is expected to remain viable for the foreseeable future.*
- Also within the Medicare umbrella, nine plans have implemented Employer Group Waiver Plans to lower costs, of those many were relatively small in size. If such a path is pursued in the Commonwealth, it warrants detailed cost saving analysis.
- Other states have also sought innovative solutions to deal with skyrocketing healthcare costs through the creation of trusts for favorable GASB treatment of liabilities
- Another strategy has been to maximize states' economies of scale by utilizing group purchasing plans for pharmaceuticals



**Kentucky Public Pension Work Group**  
**Subcommittee on Healthcare**  
**Summary of Suggested Options**

FROM: Robert Burnside  
Executive Director, Kentucky Retirement Systems

DATE: October 21, 2008

SUBJECT: Recommendations from Kentucky Retirement Systems

The Kentucky Retirement Systems recommends a partnership with the KEHP and KTRS to aggressively support disease management and wellness programs offered to actives/retirees.

The Kentucky Retirement Systems recommends a partnership KEHP and KTRS and investigate drug purchasing programs available in the marketplace in an effort to provide a cost effective pharmaceutical program to active/retirees.

The Kentucky Retirement Systems will investigate opportunities to collaborate with the Kentucky Pharmacy Association and the University of Kentucky, College of Pharmacy and other health care organizations on programs that support clinical intervention models for retirees.

The Kentucky Retirement Systems will continue to investigate alternative benefit designs for providing health care benefits to its retirees.

The Kentucky Retirement Systems will contract with the Centers for Medicare and Medicaid (CMS) and offer an Employee Group Waiver Drug Plan (EGWP) to retirees beginning in 2010.

FROM: Robert Wagoner,  
Executive Director, Kentucky Retired Teachers' Association

SUBJECT: Recommendations

The Kentucky Retired Teachers Association (KRTA) is making the following recommendations to the Health Insurance Subcommittee of the Public Pension Working Group:

KRTA would like to encourage the Kentucky Employees Health Plan (KEHP) to further explore joining the already established Ohio drug purchasing alliance/collaborative, as long as the savings proves material and each agency may keep their autonomous plan design and separate pharmaceutical benefits manager contract. Any premium savings from this action would support funding the medical benefit for retirees.

KRTA would like to recommend that the KEHP have a "most favored nations" clause in their contract with Express Scripts to ensure that the KEHP is getting the same price concessions and administrative fees as any other Express Scripts client of like nature and like size. If a "most favored nations" clause is already present in the contract between Express Scripts and the KEHP, then KRTA encourages the KEHP to exercise their right to have a "most favored nations" audit performed. Any premium savings from this action would support funding the medical benefit for retirees.

KRTA would like to recommend and support that the KEHP take necessary steps on wellness, prevention, disease management, and case management that will ultimately help with the concept of vertical integration, meaning that active state employees, active teachers, and pre-Medicare eligible retirees will, in a more healthy state, age into the Medicare Eligible Health Plans sponsored by the respective Retirement Systems. Any premium savings from this action would support funding the medical benefit for retirees.

KRTA would like to encourage the Kentucky Teachers' Retirement System (KTRS) to continue pursuing federal subsidies under the Medicare Modernization Act, including both Medicare Advantage and Medicare Part D options. Any premium savings from this action would support funding the medical benefit for retirees.

TO: Kentucky Public Pension Working Group  
Healthcare Subcommittee

FROM: John Davis, ChFC, RHU  
Arison Insurance Services

SUBJECT: Retiree Healthcare Subcommittee

Typically, health plan cost savings come through one of the following means;

- 1) Benefit reductions OR plan/carrier changes
- 2) Employee contribution sharing
- 3) Administrative cost savings
- 4) Clinical cost management
- 5) Improved wellness

Based on the presentations and research I have concluded that it is possible WITHOUT benefit reductions or changes in employee costs that it is possible to significantly reduce costs as to the Commonwealth.

This requires two major plan changes:

First, converting the current self funded KRS plan to a Medicare Advantage –PFFS plan like KTRS & many other states have and are doing now.

Second, implement an Employer Group Waiver Plan to create a PDP in place of the Current filing for Retiree drug subsidies.

FROM: Kentucky Public Retirees  
Thomas Knight, Vice president

SUBJECT: Recommendations

The Kentucky Public Retirees are making the following recommendations to the Health Insurance Subcommittee of the Public Pension Working Group:

KPR would like the Kentucky Employees Health Plan (KEHP) to investigate joining the Ohio drug purchasing alliance/collaborative or other purchasing groups. Identified savings associated with this program change would support decreasing the employer contributions for the Kentucky Retirement Systems.

KPR would like to encourage and support that the KEHP take necessary actions on wellness, prevention, disease management, and case management for members. This will decrease long term costs for the Medicare Eligible Health Plans sponsored by the Kentucky Retirement Systems as retirees migrate to these plans.

KPR would like to encourage the Kentucky Retirement System (KRS) to maintain the current benefit selections available to retirees. Premium increases have been kept to a minimum with a noted decrease in out of pocket expenses for retirees.

KPR supports KRS's pursuit of the Employer Group Waiver drug plan for retirees for plan year 2010 and continues to encourage investigation of clinical programs that will improve care coordination for retirees.